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ABSTRACT

Four fact sheets relevant to children's emotional well being are presented in this document. The first fact sheet, "Responding to Child Sexual Abuse" presents guidelines for responding to children who have been sexually abused. Information is given for reporting abuse to the local Child Protection Agency. Also discussed are issues regarding evaluation by the family physician and a psychiatrist, and testimony in court. The second fact sheet, "Children and AIDS" first presents general information about Acquired Immune Deficiency Syndrome (AIDS), and then discusses transmission of AIDS, and the parent role in education about AIDS. The third fact sheet, "When Children Have Children" discusses the long-term problems associated with babies born to teenage mothers. Consequences are also discussed for the teenage mothers in terms of physical and emotional health. Issues of abuse, neglect, and poverty are addressed, and prevention activities by the parents, school, and family planning clinics are identified. Counseling services for when pregnancy occurs are also addressed. The fourth fact sheet, "Conduct Disorders" examines a complicated group of behavioral and emotional problems in youngsters. Children and adolescents with these disorders are described as having great difficulty following rules and behaving in a socially acceptable way. Expression of anger is described as the major problem. The need for early, ongoing, comprehensive treatment is emphasized. (LLL)

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from the American Academy of Child and Adolescent Psychiatry

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Facts for Families

from the American Academy of Child and Adolescent Psychiatry

No. 28 (1/90)

RESPONDING TO CHILD SEXUAL ABUSE

When a child tells an adult that he or she has been sexually abused, the adult may feel uncomfortable and may not know what to say or do. The following guidelines are for responding to children who have been sexually abused:

What to Say

o If a child even hints in a vague way that sexual abuse has occurred, encourage him or her to talk freely. Don't make judgmental comments.

o Show that you understand and take seriously what the child is saying. Child and adolescent psychiatrists* have found that children who are listened to and understood fare much better than those who are not. The response to the disclosure of sexual abuse is critical to the child's ability to resolve the trauma of sexual abuse.

o Assure the child that he or she did the right thing in telling. A child who is close to the abuser may feel guilty about revealing the secret. The child may feel frightened if the abuser has threatened to harm the child or other family members as punishment for telling the secret.

o Tell the child that he or she is not to blame for the sexual abuse. Most children in attempting to make sense out of the abuse will believe that somehow they caused it or may even view it as a form of punishment for imagined or real wrongdoings.

o Finally, offer the child protection, and promise that you will promptly take steps to see that the abuse stops.

What to Do

Report any suspicion of child abuse. If the abuse is within the family, report it to the local Child Protection Agency. If the abuse is outside of the family, report it to the police or district attorney's office. Individuals reporting in good faith are immune from prosecution. The agency receiving the report will conduct an evaluation and will take action to protect the child.

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* Physicians with at least 5 years additional training beyond medical school in adult, child and adolescent psychiatry.

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Parents should consult with their pediatrician or family physician, who may refer them to a physician who specializes in evaluating and treating sexual abuse. The examining doctor will evaluate the child's condition and treat any physical problem related to the abuse, gather evidence to help protect the child, and reassure the child that he or she is all right.

Usually, the child should also have a psychiatric evaluation to find out how the sexual abuse has affected him or her, and to determine whether ongoing professional help is necessary for the child to deal with the trauma of the abuse. The child and adolescent psychiatrist can also provide support to other family members who may be upset by the abuse.

While most allegations of sexual abuse made by children are true, some false accusations may arise in custody disputes and in other situations. Occasionally the court will ask a child and adolescent psychiatrist to help determine whether the child is telling the truth or whether it will hurt the child to speak in court about the abuse.

When a child has to testify, special considerations--such as videotaping, frequent breaks, exclusion of spectators, and the option not to look at the accused--make the experience much less stressful.

Adults, because of their maturity and knowledge, are always the ones to blame when they abuse children. The abused children should never be blamed.

When a child tells someone about sexual abuse, a supportive, caring response is the first step towards getting help for the child, and reestablishing his or her trust in adults.

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No. 30 (1/90)

CHILDREN AND AIDS

Teenagers take many risks, but AIDS poses a dramatic new risk. Acquired immune deficiency syndrome (AIDS) is expected to kill millions of people worldwide over the next two decades. We have no known cure. AIDS is caused by a virus (HIV). One to 1.5 million Americans already may be infected with the virus, many unknowingly. Most of the infected are expected to develop full-blown AIDS, many others a lesser form of the illness, ARC (AIDS Related Complex). However, because AIDS is preventable, parents can take a number of actions to protect themselves and their children from exposure to the virus.

AIDS is not easy to catch. It is nearly certain that transmission requires a transfer of certain bodily fluids (probably not saliva or tears) from an infected to an uninfected person. These fluids include blood, semen and vaginal secretions, most commonly transmitted during a sexual act or through needle sticks or a break in the skin.

The AIDS virus survives outside the body with great difficulty and only for a short period of time. The virus is not transmitted by normal or even close social contact, or, like the cold virus, by sneezing or coughing. Members of families with an AIDS-diagnosed member have not been found to have gotten the virus, even though they have shared diaper changing, drinking glasses, bars of soap or toothbrushes. Similarly, there is no known instance in which an AIDS-infected child has passed the virus to another child in a school setting.

People infected with the HIV virus may go for many years without exhibiting the symptoms of AIDS. But they can still give it to others. This occurs mainly through intravenous drug abuse and sexual activities.

Intravenous drug abuse, aside from its other very serious risks to health, can transmit the AIDS virus. A used needle may directly introduce the virus into each person who later uses it. Tattooing and "blood brother" initiations should be avoided.

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Blood transfusion, once a serious AIDS risk, has largely been eliminated as a risk through the testing of blood products.

Transmission of AIDS may also involve sexual contact, either homosexual or heterosexual, with a person infected with HIV. Sexual activity with a series of partners greatly increase the risk. Infants have been born with AIDS transmitted from their infected mothers.

Parents should educate their children and work closely with their local schools to ensure that children and teens receive preventive drug abuse and sex education. This education should begin early within the home and should occur in many settings including churches, schools, and youth organizations, with participation of physicians. AIDS education should now be a part of sex education. Signs of drug abuse are grounds for immediate medical inquiry and intervention.

The teaching of high standards of personal behavior and interpersonal responsibility will encourage responsible restraint. Children who feel good about themselves are less likely to succumb to the pressures which lead to premature sexual activity and drug abuse, and thus high risk of AIDS. For free, general information on AIDS, write to: National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20850, or call the National AIDS Hotline, 1-(800)342-2437.

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No. 31 (1/90)

WHEN CHILDREN HAVE CHILDREN

Babies born in the U.S. to teenage mothers, especially the younger teenagers, develop long-term problems in many major areas of life, including school failure, poverty and physical or mental illness. The teenage mothers themselves are also more vulnerable to have or to develop similar serious problems.

Teenage pregnancy, especially unwed teenage pregnancy, is usually a crisis for the pregnant girl and her family and may also be a crisis for the young father and his family. Anger, guilt or denial are frequent reactions which may cause difficulty.

Adolescents who become pregnant may not seek proper medical care before the birth, leading to an increased risk for medical complications. In fact, pregnant teenagers need special understanding, medical care and education--particularly about nutrition, infections, substance abuse and complications of pregnancy. They need to learn that using tobacco, alcohol and other drugs, can damage the developing and sensitive fetus.

For the health of the mothers and babies, all pregnant teenagers should have medical care from early pregnancy. There also may be times when the pregnant teenager's emotional reactions and mental state will require psychiatric attention, often by a child and adolescent psychiatrist.*

Teenage pregnancy becomes part of a harmful pattern passed from generation to generation. Many teenage girls drop out of school to have their babies. Often the mothers and babies become part of the welfare system and enter a life of dependency that weakens the emotional and physical health of mother and child.

The teenage parents often do not really want their babies--or may want them in idealized and mixed-up ways. For example, a teenager may view the creation of a

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child as an achievement and not recognize the responsibilities. Or a teenager may want a baby to have someone to love, but not recognize the quality of care the baby needs. Often, teenagers don't foresee that their tiny and cuddly baby will also be demanding and sometimes irritating.

Babies born to teenagers may be abused or neglected, developing serious medical or mental illnesses. These babies are more likely to grow up in poverty, without proper guidance and education, and become teenage parents themselves. Thus, the harmful cycle continues.

Adult parents can help to prevent teenage pregnancy by providing guidance to their children about sexuality and the risks and responsibilities of relationships and pregnancy. School classes in family life and sexual education, as well as clinics providing reproductive information and birth control to young people, can also help to prevent pregnancy for some adolescents.

If pregnancy occurs, teenagers and their families deserve honest and sensitive counseling about options available to them, ranging from abortion to adoption. Special support systems, including child and adolescent psychiatric services where needed, should be available to help the teenager through the pregnancy, the birth and the decision about whether to keep the infant or give it up for adoption.

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No. 33 (4/90)

CONDUCT DISORDERS

"Conduct disorders" are a complicated group of behavioral and emotional problems in youngsters. Children and adolescents with these disorders have great difficulty following rules and behaving in a socially acceptable way. They are often viewed by other children, adults and social agencies as "bad" or delinquent, rather than mentally ill.

Their expression of anger is the major problem. They are often aggressive, both physically and verbally, with other children and to adults. They may lie, steal, destroy property and misbehave sexually.

Research shows that the future of these youngsters is likely to be very unhappy if they and their families do not receive early, ongoing and comprehensive treatment. Without treatment, many youngsters with conduct disorders are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job. They often break laws or behave antisocially. Many children with a conduct disorder may be diagnosed as also having a coexisting depression or an attention deficit disorder.

Many factors may lead to a child developing conduct disorders, including brain damage, child abuse, defects in growth, school failure and negative family and social experiences. The child's "bad" behavior causes a negative reaction from others, which makes the child behave even worse.

Treatment of children with conduct disorders is difficult because the causes of the illness are complex and each youngster is unique. Adding to the challenge of treatment are the child's uncooperative attitude, fear and distrust of adults.

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A child and adolescent psychiatrist* uses information from other medical specialists, and from the child, family and teachers to understand the causes of the disorder and then organize a comprehensive treatment plan.

Behavior therapy and psychotherapy are usually necessary to help the child appropriately express and control anger. Remedial education may be needed for youngsters with learning disabilities. Parents often need expert assistance in devising and carrying out special management and educational programs in the home and at school. Treatment may also include medication in some youngsters, such as those with difficulty paying attention and controlling movement or those having an associated depression.

Treatment is rarely brief since establishing new attitudes and behavior patterns takes time. However, treatment offers a good chance for considerable improvement in the present and hope for a more successful future.

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